

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

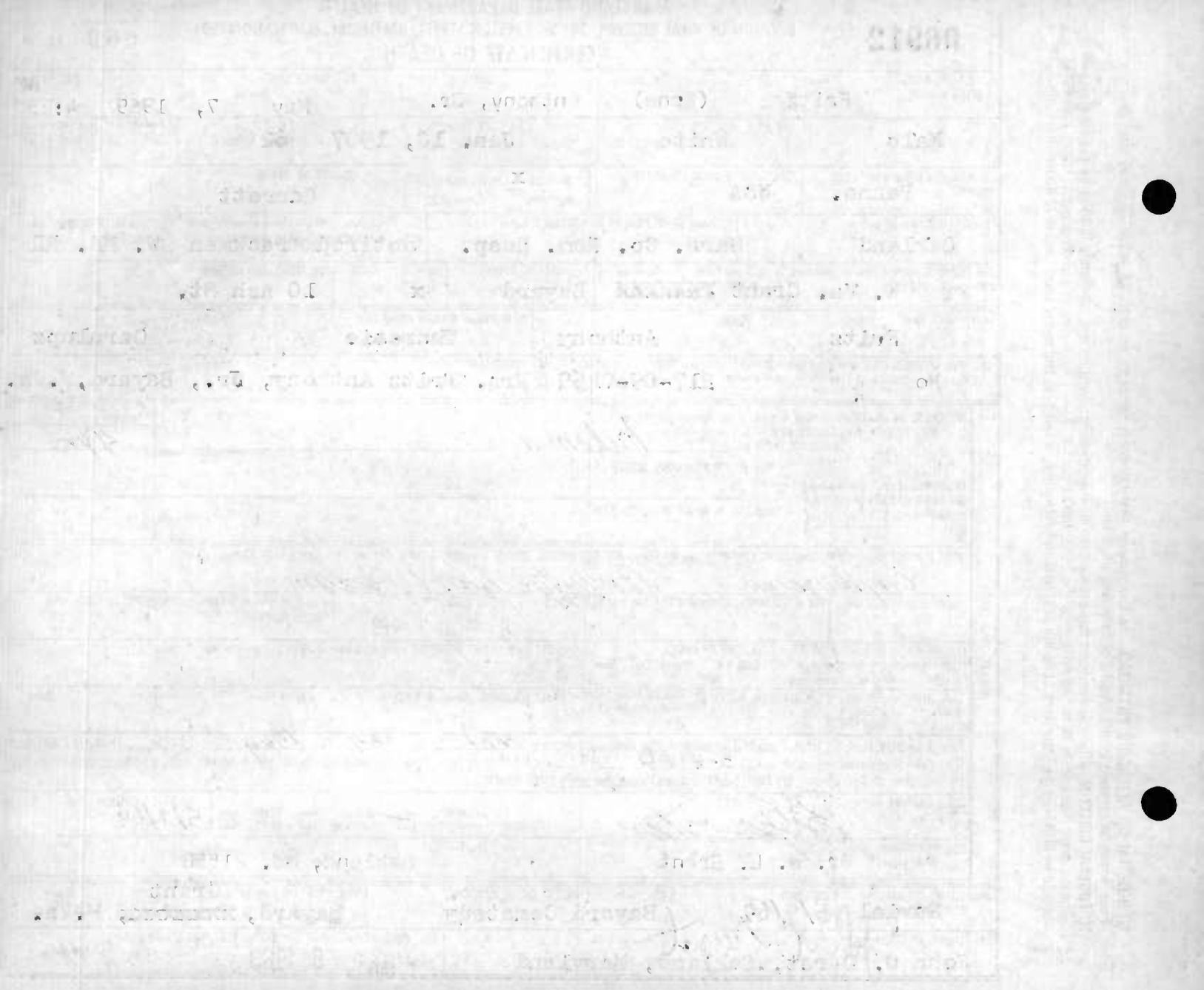
06910

CERTIFICATE OF DEATH

06912

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Fritz	Middle (None)	Lost Anthony, Jr.	2a. DATE OF DEATH Month May	Day 7	Year 1969	2b. HOUR 4:25 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 10, 1907		6. AGE (In years birthday) 62		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital name, street address) Garr. Co. Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during time of working life, even retired) Retired Trackman		12b. KIND OF BUSINESS OR INDUSTRY W. Md. RR	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va. Grant		13c. CITY OR TOWN Bayard		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10 Ash St.	
14. FATHER'S NAME First Fritz	Middle 	Lost Anthony	15. MOTHER'S MAIDEN NAME First Theresie	Middle 	Lost Garnlupz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 217-09-0459		17. INFORMANT Mrs. Fritz Anthony, Jr., Bayard, W.Va.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) leukemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4yr							
2079 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema lungs heart failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from Sept , 1969, to May , 1969, that (I) (we) last saw the deceased alive on 5-6-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE B. L. Grant		DEGREE MD	ATTENDING PHYS. MD	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/7/69	
22d. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22e. ADDRESS Oakland, Md. 21550					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/9/69		23c. NAME OF CEMETERY OR CREMATORIAL Bayard Cemetery		23d. LOCATION (City or Town, County) Grant Bayard, W. Va. (State)	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE May 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06913

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Charles	Middle Thomas	Lost Aultman	2a. DATE OF DEATH Month May	2b. HOUR Year 1969 7:25 M
3. SEX M	4. RACE W	5. DATE OF BIRTH May 11, 1886		6. AGE (In years last birthday) 83	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7b. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Garrett	Md.	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Machinist	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Garrett	13c. CITY OR TOWN Friendsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME Thomas	First Middle G.	Lost Aultman	15. MOTHER'S MAIDEN NAME Nancy	Middle ---	Lost Fordyce
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-58-6962	17. INFORMANT Mrs. Letha Aultman, Friendsville, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema - Uremia</u> 1991 DUE TO, OR AS A CONSEQUENCE OF Cardio-Vascular Failure - Renal shutdown Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <u>Complete biliary obstruction-Metastatic Carcinoma.</u> (b) <u>Primary tumor undetermined</u> DUE TO, OR AS A CONSEQUENCE OF Unknown					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Right hemi-paresis due to Cerebral Vascular Accident - 15 years duration					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY. OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from May 20, 1969, to May 29, 1969, that (I) (we) last saw the deceased alive on May 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Kurt H. Leighton</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 29 May 1969
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Oakland, Md. 21550				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/1/69	23c. NAME OF CEMETERY OR CREMATORIAL Friendsville Cem.	23d. LOCATION (City or Town) Friendsville, Garrett, Md.	(County)	(State)
24. FUNERAL DIRECTOR <u>Kurt Neumann</u>	ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR JUN 5 1969	25b. REGISTRAR'S SIGNATURE <u>Alma Judge</u>		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06914

06912

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ARCHIBALD, WELLINGTON	Middle CONNELL	Lost	20. DATE OF DEATH MAY 18	2b. HOUR 6:40 M
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH June 24, 1890	6. AGE (In years last birthday) 78	IF UNDER 1 YEAR MONTHS <input checked="" type="checkbox"/> DAYS <input type="checkbox"/>	
7b. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH GARRETT	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Postmaster		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY H Garrett	13c. CITY OR TOWN Hutton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME John Archibald Connell	15. MOTHER'S MAIDEN NAME Ella May Kirby				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. (If give war or dates of service) 293-05-1354	17. INFORMANT Miss Margaret Connell	Address Phila., Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma Lungs bilateral				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years -	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis				years	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. E. Mance		DEGREE Phys.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 17 May 69	
22d. PHYSICIAN'S NAME (Type) A. E. Mance		22e. ADDRESS Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/19/69	23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	23d. LOCATION (City or Town) Oakland, Maryland	(County) (State)
24. FUNERAL DIRECTOR Gerald D. Minnich		ADDRESS Oakland, Maryland	25a. REC'D BY REGISTRAR MAY 22 1969	25b. REGISTRAR'S SIGNATURE Charles J. Minge	

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1. DECEASED-NAME (Type or print)	First HELEN	Middle BLANCHE	Last DEVINE	2a. DATE OF DEATH Month MAY	Day 6	Year 1969	2b. HOUR 8:00 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JULY 8, 1905		6. AGE (In years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Garrett	Md.		
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp. - Housewife			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Garrett Friendsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
14. FATHER'S NAME John	First Wesley	Middle Schroyer	Last Amanda	Middle Jane	Last Sweitzer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs. Amos Friend, Friendsville, Md.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Hours		
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)					10 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER, 1968, to May 6, 1969, that (I) (we) last saw the deceased alive on May 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert H. Leighton		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 6 May 1969		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Oak @ 5th Streets, Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/10/69	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery	23d. LOCATION (City or Town) Accident, Garrett, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Footh Pearson		ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR DAMAY 13 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			

2500

DOUGLAS L. STOTTS, JR., M.D.

06916

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06914

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)			First Jennie	Middle Rebecca	Last Ellifritz	2a. DATE OF DEATH Month May	Day 21	Year 1969	2b. HOUR P 9:15 M				
3. SEX Female		4. RACE White	5. DATE OF BIRTH Jan. 23, 1895			6. AGE (In years last birthday) 74			IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Mineral Co.W.		7b. CITIZEN OF WHAT COUNTRY? Va. - U.S.A.	8. MARRIED NEVER MARRIED WIDOWED DIVORCED			9. COUNTY OF DEATH Garrett							
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during month of working life or if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Garrett	13c. CITY OR TOWN Kitzmiller			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Pee Wee Road						
14. FATHER'S NAME William		First - Puffenbarger	Middle	Last	15. MOTHER'S MAIDEN NAME Julia	First F.	Middle	Last Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-014072B.			17. INFORMANT Charles F. Ellifritz, Star Rt. Kitzmiller, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic heart disease</i> (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 2 days years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>July 21, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>A. E. Mance, M.D.</i>		DEGREE ATTENDING PHYS.	22c. DATE SIGNED <i>21 May 69</i>										
22d. PHYSICIAN'S NAME (Type) A. E. Mance, M.D.		22e. ADDRESS Oakland, Md. 21550											
23a. BURIAL, CREMATION, BURNING, ETC.		23b. DATE May 24, 1969	23c. NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery			23d. LOCATION (City or Town) Elk Garden, Mineral Co. W. Va.			(County)		(State)		
24. FUNERAL DIRECTOR <i>Arney McCloud Shapless</i>		Business, W. Va. P. O. Kitzmiller, Md.			25a. REC'D BY REGISTRAR MAY 26 1969			25b. REGISTRAR'S SIGNATURE <i>Charles J. Judd</i>					

810m

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06917 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06915

1. DECEASED-NAME (Type or Print)	First Ida	Middle Flora	Last Fratz	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI. DEATH MATED <input type="checkbox"/> 5 8 69 19	2b. HOUR 3 P M
3. SEX F	4. RACE W	5. DATE OF BIRTH Jan. 16, 1889	6. AGE (In years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.	2c. DATE PRONONCED DEAD Month Day Year 5 8 6911 45 P
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett	12d. HOUR P	
10. CITY OR TOWN OF DEATH Accident	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Garrett	13c. CITY OR TOWN Accident	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Solomon	Middle Glass	Last Anna	15. MOTHER'S MAIDEN NAME First Middle Last Margroff		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT 220-48-8777 Mrs. Erman Frazee, Accident, Md.	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Dabetes mellitus: old cerebral vascular accident				Years	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>James H. Feaster, Jr., M. D.</u>					
22b. DATE SIGNED 5-8-69					
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/11/69	23c. NAME OF CEMETERY OR CREMATORIUM Zion Church Cemetery	23d. LOCATION (City or Town) Accident, Garrett, Co., Md.	(County) (State)	
24. FUNERAL DIRECTOR <u>Frank Neumann</u>	ADDRESS Grantsville, Md.	25a. RECD BY REGISTRAR MAY 13 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

EX-101

1. REVENUE

EX-101

2. EXPENSES

3. CASH FLOW STATEMENT

4. CASH FLOW STATEMENT

FOR STATE
HEALTH DEPT.

06918

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06916

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First ORA	Middle (NMI)	Lost LAMBERT	2a. DATE KNOWN OF ESTI- MATED	Month 5	Day 1	Year 1969	2b. HOUR 1145 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost today)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 5	2d. HOUR 1 P M
Male	White	May 22, 1892	76 yrs.					Doy 1	Year 1969
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. Va.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Garrett			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done in most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rural-Oakland		Route #1, Ret. Coal Miner		Coal Miner		Soft Coal			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
		Fayette Point Marion		No <input checked="" type="checkbox"/>		Rural Box 341,			
14. FATHER'S NAME		First Harvey	Middle Lambert	15. MOTHER'S MAIDEN NAME		First UNKNOWN	Middle UNKNOWN	Last UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		(Son) ADDRESS		Pa.	
No		224-12-4149		Brinley Lambert, Box 341, Point Marion,					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Coronary thrombosis 4109</p> <p>Approximate Interval Between Onset and Death Minutes</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic cardiovascular disease Years</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>									
ACTUAL SIGNATURE: <i>James H. Feaster, Jr., M.D.</i>		22b. DATE SIGNED 5-1-69		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)								ADDRESS (Street, city, town, or county) Oakland, Garr., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 4, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Riverton Cemetery		23d. LOCATION (City or Town) Riverton, Pendleton, W. Va.		(County) (State)	
Burial									
24. FUNERAL DIRECTOR		ADDRESS John O. Durst, Oakland, Maryland		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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(15)

ATO

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Marie	Middle Ann	Lost Little	20. DATE OF DEATH Month May	06917 21 Day 1969	2b. HOUR 1:30 M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 26, 1890		6. AGE (In years last birthday) 78		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Oakland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		9. COUNTY OF DEATH GARRETT							
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Typesetter		12b. KIND OF BUSINESS OR INDUSTRY Printing							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Oakland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 709 E. Oak St.					
14. FATHER'S NAME First George David Little		Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Pfeiffer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. no 215-01-9076		17. INFORMANT Alice Turney		Address Oakland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>Rheumatoid Arthritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arthritis</u> <u>deformities</u> -								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>20 May 69</u> , 19 <u>69</u> , to <u>21 Aug 69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>20 May 69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>A. E. Mance, M.D.</u>				22c. DATE SIGNED <u>21 May 69</u>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Oakland, Maryland 21550											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/24/69		23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery		23d. LOCATION (City or Town) Oakland		(County) Maryland		(State)			
24. FUNERAL DIRECTOR Gerald N. Minnick		ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles George							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06920

06918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First	Middle	Last	20. DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b. HOUR
Gilbert Troy Lowdermilk				<input checked="" type="checkbox"/>	5	8	1969	14:44 A.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years from birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2d. HOUR
Male	White	2/26/1888	81 YRS.					10 A.M.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
Maryland	USA		GARRETT					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
Oakland	Star Route	Miner	Coal					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Maryland	Garrett	Crellin	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
James		Lowdermilk		Safronia			DeWitt	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS					
no	213-01-5646-A	Bessie Lowdermilk	Crellin, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF 4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> Years DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John H. Feaster, Jr.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 5-8-69		
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/10/69	23c. NAME OF CEMETERY OR CREMATORIUM Kisner Cemetery	23d. LOCATION (City or Town) Crellin, Maryland	(County)	(State)		
24. FUNERAL DIRECTOR <i>Gerald J. Minnich</i>		ADDRESS Oakland, Md.	25a. REC'D BY REGISTRAR MAY 13 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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